

Unannounced Care Inspection Report 21 February 2018



Tudordale

Type of Service: Nursing Home (NH)
Address: 294 Hollywood Road, Belfast, BT4 1SG
Tel No: 0289065 1336
Inspector: Elizabeth Colgan

www.rgia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for



2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 45 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care Responsible Individual: Dr Maureen Claire Royston	Registered Manager: Rosalind Morrison
Person in charge at the time of inspection: Rosalind Morrison	Date manager registered: 3 January 2018
Categories of care: Nursing Home (NH) DE – Dementia	Number of registered places: 45

4.0 Inspection summary

An unannounced inspection took place on 21 February 2018 from 09.35 to 15.15 hours.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

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Evidence of good practice was found in relation to staff recruitment, induction, training and development, adult safeguarding arrangements, risk management, care delivery and effective communication systems. The culture and ethos of the home promoted treating patients with dignity and respect. There was also evidence of good practice identified in relation to the governance and management arrangements; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home. The environment of the home was conducive to the needs of the patients and the addition of a dementia café for patients and their relatives to use was a very positive step forward.

Areas requiring improvement were identified and included infection prevention and control practices and supplementary care records.

Patients and their representatives said that they were satisfied with the care and services provided and described living in the home, in positive terms.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Rosalind Morrison, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 14 June 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 14 June 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing .
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with 10 patients, five staff, and four patients' visitors/representatives. Questionnaires were left in the home to obtain feedback from patients and patients' relatives. A poster was also displayed for staff inviting them to provide online feedback to RQIA.

The following records were examined during the inspection:

- duty rota for all staff from weeks commencing 12 and 19 February 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- three staff recruitment and induction files
- four patient care records
- a selection of patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits

- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability monthly unannounced quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 June 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 14 June 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 Ref: Standard 41.1 Stated: First time	The registered person shall ensure that the staffing arrangements are reviewed in accordance with the dependency levels of patients and for example; staff workload and the time of day.	Met
	Action taken as confirmed during the inspection: Review of documentation, observation and discussion with the registered manager and staff confirmed that the staffing arrangements are reviewed in accordance with the dependency levels of patients and for example; staff workload and the time of day.	

Area for improvement 2 Ref: Standard 4.8 Stated: First time	The registered person shall ensure that a review of the comprehensive needs assessment for each patient is reviewed on at least an annual basis or as and when need changes.	Met
	Action taken as confirmed during the inspection: Review of documentation confirmed that the comprehensive needs assessment for each patient had been reviewed on an annual basis or on the changing needs of the patients.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 12 and 19 February 2018 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment and staff supervision and appraisals are regular and ongoing.

Review of the training matrix/schedule for 2017/18 indicated that training was planned to ensure that mandatory training requirements were met. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training.

Staff spoken with clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

A review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and generally clean throughout. Patients, their representatives, and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement relating to infection prevention and control measures and practices were identified as follows:

- there was communal use of medicines syringes
- one sharps bin was not signed or dated
- cleaning schedules should include skirting boards

These actions were discussed with the registered manager and an area for improvement was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, risk management and the home's environment.

Areas for improvement

An area was identified for improvement in relation to infection prevention and control.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Review of four patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. However, review of supplementary care charts such as food/fluid intake records evidenced that records were not always maintained in accordance with best practice guidance, care standards and legislation. Deficits were noted in completion of these records. For example, records were not fully completed or totalled at the end of the day. Also recordings in the evenings and during the night were often missing. This was discussed with the registered manager and an area for improvement under the care standards was stated.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), SALT, dietician and TVN.

Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Staff confirmed that staff meetings were held monthly and that the minutes were made available. Staff stated that there was effective teamwork, each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their registered manager or regional manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patient representatives spoken with expressed their confidence in raising concerns with the home’s staff/management. Patient representatives knew the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to audits and reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

An area for improvement was identified against the standards in relation to supplementary care records

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. For example staff were observed to knock on patients doors before entering, and kept them closed when providing personal care. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

The serving of the midday meal was observed. Tables were attractively set with cutlery and napkins. A range of condiments and drinks were readily available. The menu was displayed in the dining rooms. The meals were pleasantly presented, were of good quality and smelt appetising. All of the patients spoken with enjoyed their lunch. The care assistants were observed supervising and assisting patients with their meal and monitoring patients’ nutritional intake. Hot meals were covered when transferred from the dining room to the patients’ preferred dining area and care assistants were observed assisting patients who were unable to eat independently with their lunch. PPE was worn by staff involved with the serving or assisting patients with the meal.

Patients and/or patient representatives consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. There was a personal activities leader (PAL) responsible for the provision of activities in the home. Discussion with the PAL evidenced a varied programme planned to meet the individual needs of the patient’s. There was evidence of a variety of activities in the home and discussion with staff confirmed that patients were given a choice with

regards to what they wanted to participate in. There were various records and photographs displayed around the home of patients' participation in recent activities. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. For example an electronic feedback system was also situated in the reception area. This was available to relatives and other visitors to give general feedback on an ongoing basis or answer specific questions on the theme of the month. The feedback was summarised automatically by the system and the results were available to the registered manager and the regional manager.

Staff and patient representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner.

During the inspection 10 patients, five staff, and four patients' visitors/representatives were consulted with. Some comments received are detailed below:

Patients

"I'm happy but it's not home."

"The staff are good and kind."

"The food is ok, I get what I need."

"Staff care for me very well."

Patients' representatives

"Staff are very approachable."

"Very satisfied with the care my relative gets."

"I feel my relative is treated well."

"Our wishes are respected."

"The manager is good."

Staff

"I think there is good care."

"I feel supported here."

"Everyone works well together."

"The patients are well cared for."

Questionnaires were left in the home to obtain feedback from patients and patients' relatives. A poster was also displayed for staff inviting them to provide online feedback to RQIA. No questionnaires were returned from patients and patients' relatives and no staff completed the online questionnaire within the agreed timescale.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes and activities were also well managed.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients, and representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager and review of records and observation evidenced that the home was operating within its registered categories of care.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a yearly basis. Staff confirmed that they had access to the home's policies and procedures.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patient representatives spoken with confirmed that they were aware of the home's complaints procedure. A copy of the complaints procedure was available in the home and staff were knowledgeable of the complaints process.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

As a further element of its Quality of Life Programme, Four Seasons Health Care operate a Thematic Resident Care Audit (“TRaCA”) which home managers can complete electronically. Nursing homes which have attained the DCF accreditation complete the ‘TraCA D’ information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. Discussion with the registered manager and review of records evidenced that Regulation 29 (or monthly quality) monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Rosalind Morrison, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Care Standards for Nursing Homes (2015).

<p>Area for improvement 1</p> <p>Ref: Standard 46</p> <p>Stated: First time</p> <p>To be completed by: 21 February 2018</p>	<p>The registered person shall ensure suitable arrangements are in place to minimise the risk of infection and spread of infection.</p> <p>Ref: Section 6.4</p> <p>Response by registered person detailing the actions taken: Nursing staff have received supervision on ensuring that the sharps box is signed and dated and has the appropriate waste, and that all oral syringes should be kept with the specific patients own medicine and washed after each use to avoid communal use of oral syringes. Cleaning and repainting of skirting boards particularly around lounges and dining rooms to be included and a painting programme of such areas rolled out.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 12</p> <p>Stated: First time</p> <p>To be completed by: 21 February 2018</p>	<p>The registered provider shall ensure that food and fluid intake records reflect a full 24 hours and that the total intake/output are collated into the patient's daily progress records.</p> <p>Ref: Section 6.5</p> <p>Response by registered person detailing the actions taken: The staff have received further supervision on completing fully throughout the 24 hour period the fluid intake charts including totalling the amounts at the end and recording in the progress notes, the handover record that totals the amount of fluids over am, pm and night duty which is later transferred in the daily progress has been reviewed.</p>

Please ensure this document is completed in full and returned via Web Portal



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